11.1 CHRONIC PELVIC PAIN

AEROMEDICAL CONCERNS: Chronic recurrent pain can be a distraction in flight and may occasionally cause incapacitation. Chronic pelvic pain is defined as pelvic pain present throughout most of the menstrual cycle for 3 or more months. The causes of chronic pelvic pain include gynecological etiology, GI tract, urinary tract, musculoskeletal, and psychiatric conditions. Aircrew should be grounded during a work-up for chronic pelvic pain until the etiology is known and the condition is controlled. Waivers may be considered for the individual causes.

WAIVER: Chronic pelvic pain is CD. Waiver recommendations will be highly individualized depending on cause and degree of treatment.

INFORMATION REQUIRED:

1. Full gynecological evaluation
2. GI consult (as appropriate)
3. Orthopedic consult (as appropriate)
4. Psychiatry consult (as appropriate)

TREATMENT: If chronic pelvic pain is of gynecologic etiology, more than 50% of cases will be controlled with NSAIDS and oral contraceptives. Laparoscopy may be required for diagnosis and treatment. Therapy should be directed at the cause and, if successful, a waiver should be recommended.

DISCUSSION: Gynecological causes for chronic pelvic pain include:

- Endometriosis
- Dysmenorrhea
- Adhesive disease
- Uterine fibroids
- Ovarian cysts
- Adenomyosis
- Pelvic Inflammatory Disease/Infection

11.2 CERVICAL DYSPLASIA

AEROMEDICAL CONCERNS: There are no specific aeromedical concerns for cervical dysplasia. Treatment for cervical dysplasia may require temporary grounding for a period of 2-4 weeks after surgical procedures. The need for frequent retreatment or follow-up may restrict deployability.

WAIVER: Not required. Condition is NCD. Carcinoma in Situ (CIS) or any degree of malignancy is CD and considered for waiver on a case by case basis. See Chapter 9, Malignancies, for further guidance.

INFORMATION REQUIRED:

1. Gynecological evaluation
2. Follow-up is recommended as per the member's Gynecologist

TREATMENT: Dysplasia may require frequent colposcopy and biopsy and increased frequency of Pap smear follow-up. High-grade squamous intraepithelial lesions (HGSIL) require colposcopy and may need surgical treatment (LEEP, Cold knife conization (CKC)). Evaluation of HGSIL is not emergent and should be performed within 2-4 months. Low grade SIL requires repeat pap smears at 3-4 month intervals and, if persistently abnormal, should be treated as HGSIL.

DISCUSSION: The current grading system for pap smears is quite simple and includes only normal, LGSIL, or HGSIL. The cytopathologist's comments on adequacy of specimen and other minor abnormalities tend to be confusing. Anything less than HGSIL need only be followed with pap smears every 3-6 months. There is nothing about dysplasia per se that is disqualifying, but it is important to note that abnormal pap smears should NOT be ignored and gynecology consultation is recommended.

ICD-9 CODE:
622.1 Cervical dysplasia

11.3 ENDOMETRIOSIS

AEROMEDICAL CONCERNS: Dysmenorrhea, intermenstrual pain, and backache can be distracting and the menorrhagia in some women can produce anemia. There is also a rare association with spontaneous pneumothorax.

WAIVER: Mild endometriosis, requiring only mild analgesia and oral contraceptive pills is NCD. The use of any medication requires supervision by a Flight Surgeon. For more recalcitrant cases, a waiver can be recommended when the symptoms are controlled; recommendations will be on a case-by-case basis depending on symptoms and medications.

INFORMATION REQUIRED:

1. Gynecology evaluation

TREATMENT: Mild analgesia is permitted without requiring a waiver. The use of progesterone or anti-gonadotropin agents such as Danazol may be compatible with selected flight duties once the patient is stabilized on therapy. Patients may also return to flying duties after conservative surgical treatment including laser ablation.

DISCUSSION: Danazol, if used for medical treatment of endometriosis to suppress the pituitary-ovarian axis, may cause fluid retention. An increase in the incidence of migraine cephalgia has also been reported. Gonadotropin releasing hormone (GnRH) analogs can lead to perimenopausal symptoms including hot flashes and mood alterations. The ultimate cure of endometriosis is total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAHBSO). Following this procedure, patients should be placed on estrogen replacement therapy and should be considered fit for duty without need for waiver.

ICD-9 CODES:
617 Endometriosis
617.0 Endometriosis of uterus
617.9 Endometriosis, site unspecified

11.4 HORMONAL REPLACEMENT THERAPY AND CONTRACEPTION

DEFINITION: Hormonal replacement therapy and contraception includes birth control, estrogen replacement therapy, and hormone replacement therapy.

AEROMEDICAL CONCERNS: Alterations of hormone balance may lead to nausea and vomiting, depression, bloating, and emotional irritability. Regardless of the reasons for initiation of estrogen hormones, an initial down period of two weeks in order to assess tolerance is recommended.

WAIVER: Waiver is not required. Use of estrogen and progesterone preparations is NCD.

INFORMATION REQUIRED:

2. Annual gynecological exam per OPNAVINST 6000.1 series
    a. Pap smear
    b. Breast examination
    c. Pelvic exam

TREATMENT: None

DISCUSSION: Oral contraceptives in the current dosing formulations contain very low doses of estrogen/progesterone and have minimal side effects. If a patient has taken any preparation of oral contraceptive pill in the past and tolerated it well, a down period is not required. However, as with all medications, the use (or resumption) of contraceptive medication must be with the approval of the local flight surgeon. Side effects of combination oral hormonal contraceptives may include nausea, vomiting, depression or irritability, weight gain and headaches. Side effects of progesterone only preparations (Depo-Provera, Micronor, Norplant, etc.) may include depression, irregular vaginal spotting, bloating, and fluid retention.

Estrogen replacement therapy is generally well tolerated when given in recommended physiologic doses and is strongly recommended for all women without endogenous production of estrogen. Replacement therapy constitutes reestablishing the normal physiologic levels of estrogen/progesterone. This replacement should not be construed as introducing a foreign chemical into the body but rather the restoration of the natural state. Estrogen replacement therapy involves a lower dose of estrogen than is in use in currently available oral contraceptives (Ethinyl estradiol in a dose of 5 micrograms is equivalent to 0.625mg conjugated estrogens).

11.5 PELVIC INFLAMMATORY DISEASE

AEROMEDICAL CONCERNS: Pelvic inflammatory disease is an acute infection of the upper female genital tract characterized by severe lower abdominal pain. Sequelae can include chronic pelvic pain and infertility. Aviation personnel should be grounded during treatment of the acute phase.

WAIVER: A history of pelvic inflammatory disease (PID) in female aircrew who are symptom free is NCD. Female aircrew members who have chronic pelvic pain as a sequelae to PID should be evaluated by a Gynecologist and a waiver may be recommended on a case-by-case basis.

INFORMATION REQUIRED:

1. Gynecology consult
2. Documenting resolution of acute PID

TREATMENT: Antibiotic treatment during the acute phase will result in grounding. Initial outpatient treatment is Rocephin® 250 mg IM plus Doxycycline 100 mg bid for 14 days. Patients should be re-evaluated in two days if symptoms are not better. In those cases, the diagnosis of PID should be reconsidered or the patient should be admitted to the hospital for IV antibiotic treatment. Surgical treatment for the sequelae of PID (adhesions) is compatible with a return to flying duties. Patients may return to flying one week after laparoscopy provided they remain asymptomatic.

DISCUSSION: The incidence of PID in the US is approximately 1% in young females. The diagnosis of pelvic inflammatory disease is made based upon the triad of abdominal pain, cervical motion tenderness, and adnexal tenderness (usually bilaterally) along with any one of multiple non-specific indications of inflammation or infection (e.g. temperature elevation, leukocytosis, leukorrhea, etc). Many women are improperly diagnosed with PID, and definitive diagnosis is made with laparoscopy. Sequelae include pelvic adhesions, infertility, chronic pelvic pain, and increased risk for ectopic pregnancy.

ICD-9 CODE:
614.9 Pelvic Inflammatory Disease

11.6 PREGNANCY

AEROMEDICAL CONCERNS: The physiologic changes of pregnancy, compounded by the physiologic stresses of aviation duty, pose a possibility of significant risk to the mother and fetus. Among these are vibration, hypoxia, Gz forces, and other stresses of the aviation environment that may have an undesirable effect on the developing fetus or the continuation of the pregnancy. Gz forces and ejection are likely to be unwise throughout the entire pregnancy. During the first trimester, there is a risk of incapacitation from rupture of a tubal/ectopic pregnancy or from spontaneous abortion. In the final trimester, increasing fetal size and the risk of hemorrhage or premature labor make military flying unwise.

WAIVER: Specific guidance on pregnancy in flight personnel contained in the most current version of OPNAVINST 3710.7 must be followed. Undelivered intrauterine pregnancy is CD for all DIF except for air traffic controllers. Flight personnel are grounded during pregnancy unless a clearance to continue in flight status is granted by the aviation unit commanding officer.

NOTE: Pregnancy is a unique circumstance under which the CO has waiver authority, a right otherwise reserved for HQ USMC and PERS. The member must request the waiver with concurrence by the obstetric care physician and the local or unit flight surgeon. Physical standards for flight personnel may only be waived to permit flight in Transport/Maritime/Helo type aircraft with a cabin pressure of 10,000 feet or less. No solo flight or ejection seat flight will be considered for waiver. DNA's shall be recommended for waiver to SG3 only to include no shipboard operations. Only an uncomplicated pregnancy will be considered for waiver recommendation. A Local Board of Flight Surgeons including a specialist (Family Practice or OB/GYN) shall be held prior to issue of a medical clearance. When the LBFS has recommended a waiver for continued flight in an uncomplicated intrauterine pregnancy and the CO approves the waiver request, the LBFS AMS and the CO's final action must be submitted to NAMI Code 342 for review. NAMI Code 342 will then forward a final aeromedical disposition recommendation and the CO's final action to PERS or HQ USMC/ASM. If a LBFS is not conducted, a clearance notice may not be issued. If the member does not request a waiver, the LBFS does not recommend a waiver, or the CO denies a waiver request, the LBFS AMS and/or CO's final action must be forward to PERS or HQ USMC/ASM and NAMI Code 342. If the aircrew member becomes pregnant during aviation training, she shall be grounded until after completion of the pregnancy and return to normal full duty. For air traffic controllers the decision to ground is up to the local commanding officer as advised by the flight surgeon. Don't ask for waivers.

For CNATRA Personnel: Air controllers may work into the third trimester in a supervisory capacity only and not in the tower. Other commands may also consider such a course of action prudent.

INFORMATION REQUIRED:

1. "information only" aeromedical summary, which must include the following:
    a. Estimated date of confinement (EDC)

b. Estimated date for return to full duty
c. Statement that the member "acknowledges an understanding of the potential risks of continued flying during pregnancy"
d. Confirmation of uncomplicated intrauterine pregnancy by Family Practice or OB/GYN
e. Obstetric consult (if there has been an obstetric complication)

FOLLOW-UP: Upon termination of pregnancy, a post-grounding complete physical examination shall be submitted to NAMI-342. This exam must include:

1. Information regarding any complications encountered during pregnancy
2. Information on the health of the child and mother following delivery

TREATMENT: N/A.

DISCUSSION: The reasons for restrictions vary with stage of pregnancy. In the second trimester, the fetus is theoretically well protected against the aviation environment with its own liquid filled anti-G suit and with fetal hemoglobin. The restrictions in the final trimester are related to the increased risk of premature labor that is reported to occur with reduced atmospheric pressure and to the increasing physical difficulty in carrying out military duties. The possible teratogenic effects and the CO responsibility to protect pregnant service members have been addressed in OPNAV 6100.1B, although informed consent is not required.

Prior to any waiver recommendation, carefully consider the effects of pregnancy on any aviator, including how she is coping with the physiologic, emotional, and instructional stresses of pregnancy. In many cases it may not be advisable to request a waiver; recommendations should be in concert with the patient's needs and desires along with those of the command.

Ref: OPNAVINST 3710.7T, p. 8.3.2.8

ICD-9 CODE:
V22 Uncomplicated Pregnancy